

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
C8528 CERTIFICATE OF DEATH

08532

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X C CRELLIN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ARTHUR LYNN BOWMAN		First ARTHUR	Middle LYNN
4. DATE OF DEATH AUGUST 11, 1957	Month AUGUST	Day 11	Year 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/10/57
9. AGE (In years lost birthday) yrs. 40	10. IF UNDER 1 YEAR Months 40	11. IF UNDER 24 HRS. Days 13	Hours 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CLARENCE EDWARD BOWMAN, JR.		14. MOTHER'S MAIDEN NAME VIRGINIA MAY HOSE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT CLARENCE EDWARD BOWMAN, JR., CRELLIN, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 527.2		INTERVAL BETWEEN ONSET AND DEATH 2 Days	
DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the under-lying cause lost. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10 Aug., 1957 , to 11 Aug., 1957 , that I last saw the deceased alive on 11 Aug., 1957 , and that death occurred at 10:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. E. Mance		ADDRESS (Street, city or town, state) Oakland, Md.	
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.		DATE SIGNED 12 Aug. 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 14, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Ashby Cemetery
22d. LOCATION (City, town, or county) Crellin, Maryland.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE P.R. Watson		24a. REC'D BY REGISTRAR 8/14/57	24b. REGISTRAR'S SIGNATURE Julie Mance

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DATA

BUREAU V. S.
RECEIVED
AUG 27 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08529

CERTIFICATE OF DEATH

Reg. Dist. No. 08533

1. PLACE OF DEATH a. COUNTY Garrett County		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accident		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing 01x0.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Watercliffe Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Margaret		First Graham	Middle Boyd
4. DATE OF DEATH Aug, 14th. 1957	Month 1957	Day 14	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 19th. 1874
9. AGE (In years lost birthday) 83	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher		11. BIRTHPLACE (State or foreign country) Lonaconing, MD.	
13. FATHER'S NAME John M. Boyd		14. MOTHER'S MAIDEN NAME Mary Ann Spears	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Melvin Kesner, Accident, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 20 yrs.	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		I left ventricular Failure 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Possible Gastrointestinal hemorrhage		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) White Not while at work	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 48 BROADWAY	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from 8/12/57 , 19, to 8/14/57 , 19, that I last saw the deceased alive on 8/14/57 , 19, and that death occurred at 7:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frostburg, MD. DATE SIGNED 8/14/57			
ACTUAL SIGNATURE MARTIN M. ROTHSCHILD M.D.			
PHYSICIAN'S NAME (Type) MARTIN M. ROTHSCHILD M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug, 16, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery	22d. LOCATION (City, town, or county) LONACONING, MD. (State)
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN, LONACONING, MD.		24a. REC'D BY REGISTRAR DATE AUG 27 '57	
		24b. REGISTRAR'S SIGNATURE Alfred	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 17

CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
AUG 27 1957

RECEIVED

AUG 19 1957

GARRETT COUNTY
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08530 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08534
166

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE W. VA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b ?	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TERRA ALTA 85x-3 ✓	
d. STREET ADDRESS RT 4		d. DATE OF DEATH Month AUGUST Day 3 Year 1957	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EARL	First LESLIE	Middle FREELAND	4. DATE OF DEATH Month AUGUST Day 3 Year 1957
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 4-1885
9. AGE (in years last birthday) 72yrs	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) W. VA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES W. FREELAND		14. MOTHER'S MAIDEN NAME ELIZABETH BRAHAM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 234-32-8195	
17. INFORMANT WARDEN FREELAND - Youngstown		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CROSTING INJURIES FACE, SKULL & CHEST			
DUE TO 802X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) WITH RUPTURED LUNGS			
DUE TO (c)			
INSTANT			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Fracture rt knee - Left ankle			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by RR. Locomotive	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8/3 1957 p. m. 75		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) YRKE. Crossings - OAKLAND GARRET		20f. (City or town) (County) (State) OAKLAND GARRET	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. I. Baumgartner		DATE SIGNED 8/6/57	
EXAMINER'S NAME (Type) E. I. BAUMGARTNER		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 8/6/57	
22c. NAME OF CEMETERY OR CREMATORIAL TERRA ALTA		22d. LOCATION (City, town, or county) TERRA ALTA (State) W. VA	
23. FUNERAL DIRECTOR'S SIGNATURE Emerson Bolden Oakwood Ma		ADDRESS 816/57	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Julia Kavanagh	

STATE OF CALIFORNIA
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V.
RECEIVED
AUG 14 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08535

08531

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH o. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Star Route		c. LENGTH OF STAY IN 1b 8 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		d. STREET ADDRESS 29 Frost Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Happy Hills Farm				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JACOB		First	Middle	Lost	4. DATE OF DEATH Month 8	Day 8	Year 1957
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb 22, 1866	9. AGE (In years lost birthday) 91 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture & Funeral		10b. KIND OF BUSINESS OR INDUSTRY Own business		11. BIRTHPLACE (State or foreign country) New Morchen, Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Hafer		14. MOTHER'S MAIDEN NAME Elizabeth Berg					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Frank A. Mattingly, Frostburg, Md.		Address 29 Frost Avenue, Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio -						INTERVAL BETWEEN ONSET AND DEATH 5 years	
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Vascular disease					
(c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senility						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 39th Main St.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-15-50 , 1957, to 8-8 , 1957, that I last saw the deceased alive on 8-2 , 1957, and that death occurred at 69 M, from the causes and on the date stated above. ACTUAL SIGNATURE H.C. Dietl						ADDRESS (Street, city or town, state) 89157	
PHYSICIAN'S NAME (Type) H.C. Dietl, M.D.						DATE SIGNED 8-9-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-10-57		22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home		ADDRESS 23 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR 8-9-57		24b. REGISTRAR'S SIGNATURE Miss Nellie H. Rose	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

NAME	SEX	AGE	CAUSE OF DEATH
WILLIAM J. HANNAH	M	50	ACUTE CARDIOPNEUMONIA
ADDRESS	STATE	CITY	ZIP
111 E. 36TH ST.	MD	BALTIMORE	21205
RELATIONSHIP	AGE	SEX	CAUSE OF DEATH
WIFE	50	F	ACUTE CARDIOPNEUMONIA
DEATH DATE	TIME	PLACE	DEATH CERTIFIED
AUGUST 12, 1957	10:00 AM	HOSPITAL	BY DOCTOR
DEATH CERTIFIED	DOCTOR'S SIGNATURE	DOCTOR'S ADDRESS	DOCTOR'S LICENSE NO.
BY DR. RICHARD L. COOPER	RICHARD L. COOPER	111 E. 36TH ST.	MD 10000

BUREAU V. S.

AUG 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08536
166

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH COUNTY Garrett CITY (If outside corporate limits, write RURAL OR and give nearest town) Oakland		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Kitzmiller	
MARYLAND LENGTH OF STAY (In this place) 6WKS		COUNTY Garrett (If rural give location) STREET ADDRESS 1 W. Main Street	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Evans Nursing Home			
3. NAME OF DECEASED (Type or Print) (First) Edward Jackson (Middle) (Last) Hamill		4. DATE (Month) (Day) (Year) OF DEATH August 25 57	
5. SEX Male	6. COLOR OR Race White	7. SINGLE, MARRIED, WIDOWED - DIVORCED (Specify) Widowed	8. DATE OF BIRTH August 8, 1865
9. AGE last birthday 92 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired - Cashier	11. KIND OF BUSINESS OR INDUSTRY Bank	12. BIRTHPLACE (State or foreign country) Kitzmiller, Md.
13. FATHER'S NAME Henry Hamill	14. MOTHER'S MAIDEN NAME Julia Ann Fazenbaker		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> No <input type="checkbox"/> unk.)	16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Gladys B. Hamill-Kitzmiller, Md.
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 442X IMMEDIATE CAUSE (A) Acute myocardial infarction ANTECEDENT CAUSE(S) DUE TO (B) chronic cardiac vascular renal disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. They were of old age			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from..... alive on Aug. 24, 1957, and that death occurred at 4:45A.M., from the causes and on the date stated above. SIGNATURE Ralph Colandella M.D. ADDRESS E.S.T. Kitzmiller, Md. DATE SIGNED Aug 26-57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 28/57 NAME OF CEMETERY OR CREMATORIUM Hamill Cemetery	
24. REG'D BY REGISTRAR DATE 7/26/57		REGISTRAR'S SIGNATURE John Howes	
25. FUNERAL DIRECTOR'S SIGNATURE DATE		ADDRESS O.F. Sharpleas Blaine, W.Va.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08533 CERTIFICATE OF DEATH

Reg. Dist. No.

08537
166

1. PLACE OF DEATH o. COUNTY		Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin		c. LENGTH OF STAY IN 1b 25 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Crellin, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Iva	Middle Harrett	Last Hayes	4. DATE OF DEATH August 24,	Month 1957.	Day Year
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1888		9. AGE (In years lost birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tunnelton, West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Newton Michaels				14. MOTHER'S MAIDEN NAME Sara Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT J. W. Hayes,		Address Crellin, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Sclerosis</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN DEATH AND DEATH 8 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>16 April, 1957</u> to <u>24 Aug. 1957</u> , that I last saw the deceased alive on <u>24 Aug. 1957</u> , and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) Oakland, Maryland.							
ACTUAL SIGNATURE <u>Andrew E. Mance</u>	DATE SIGNED 25 Aug 57						
PHYSICIAN'S NAME (Type) ANDREW E. MANCE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 27, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Shay's Chapel Cemetery	22d. LOCATION (City, town, or county) Tunnelton, West Virginia (State)				
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.W. Watson</u>		ADDRESS Terra Alta, W.Va.	24a. REGISTERED BY REGISTRAR DATE 8/24/57	24b. REGISTRAR'S SIGNATURE <u>Julia Morgan</u>			

THE STATE OF CALIFORNIA
DEPARTMENT OF MOTOR VEHICLES

Ergonomics

BUREAU V. S.

AUG 28 1957

REGELIVÉD

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

The postmortem may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

I

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08538

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	GARRETT RURAL ACCIDENT	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS	LIFE MD RURAL ACCIDENT		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
SEX <i>M</i>	COLOR OR RACE <i>W</i>	SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>MARRIED</i>	(Month) AUG (Day) 5 (Year) 1957
5. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i>		6. 10b. KIND OF BUSINESS OR INDUSTRY <i>OWN FARM</i>	
11. BIRTHPLACE (State or foreign country) <i>GARRETT Co</i>		7. DATE OF BIRTH <i>APRIL 6 1877</i>	
8. AGE last birthday <i>80</i>		9. IF UNDER 1 YEAR yrs. Months Deys	10. IF UNDER 24 HRS. Hours Min.
13. FATHER'S NAME <i>JOHN C HETRICK</i>		14. MOTHER'S MAIDEN NAME <i>Laura Kinney</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT & ADDRESS <i>Orlando Hetrick, Accident Md</i>		18. MEDICAL CERTIFICATION <i>Heart disease, myocardial infarct Arteriosclerosis</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		<i>1 mo</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<i>10 yrs</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) <i>St. John's Code</i>		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June 1957</i> to <i>Aug 5, 1957</i> , that I last saw the deceased alive on <i>Aug 5, 1957</i> , and that death occurred at <i>12:15 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>Ron Lumbt MD</i> DATE SIGNED <i>8/6/57</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>8/8/57</i>	
24. REC'D BY REGISTRAR <i>AUG 13 1957</i>		NAME OF CEMETERY OR CREMATORIAL REGISTRAR'S SIGNATURE <i>St. John's Code</i>	
		LOCATION (City, town, or county) 25a. FUNERAL DIRECTOR'S SIGNATURE <i>Accident, GARRETT Co, Md</i>	
		ADDRESS <i>Donald J. Newman, Gantville, Md.</i>	

DATE

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08535

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

085396

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Near) Oakland		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 01222	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Eugene Clement Jeffries		First Eugene	Middle Clement
4. DATE OF DEATH Aug. 25th. 1957		Last Jeffries	Month Aug. Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 5th. 1936
9. AGE (in years last birthday) 21 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Frostburg, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clement Jeffries		14. MOTHER'S MAIDEN NAME Margaret McKenzie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-34-1780	
17. INFORMANT Mrs. Eugene Jeffries, Frostburg, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning		INTERVAL BETWEEN ONSET AND DEATH Instant	
DUE TO 850x			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Boat Capsized and Sunken.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:30 8-25 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Lake
20f. (City or town) Nr. Oakland		(County) Garrett (State) MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		DATE SIGNED 8-25-57	
EXAMINER'S NAME (Type) JAMES H. FEASTER, JR. M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTING	
22a. BURIAL, CREMATION, REMOVALS Burial)		22b. DATE THEREOF Aug. 28, 1957	
22c. NAME OF CEMETERY OR CREMATORIALy Memorial Park		22d. LOCATION (City, town, or county) Frostburg, MD. (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lenacening, MD.	
24a. REG'D BY REGISTRAR Julia L. Feaster		24b. REGISTRAR'S SIGNATURE Julia L. Feaster	
DATE 9/28/57		DATE 9/28/57	

MANITOBA STATE GOVERNMENT OF HAMILTON - BAPTIST HOME

MEDICAL DEPARTMENT CERTIFICATE OF DEATH

NAME OF DECEASED

NAME OF DOCTOR

NAME OF HOSPITAL

DECEASED

(CONT'D.)

NAME OF DECEASED

NAME OF DOCTOR

NAME OF HOSPITAL

NAME OF DECEASED

NAME OF DOCTOR

NAME OF HOSPITAL

NAME OF DECEASED

NAME OF DOCTOR

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NAME OF DECEASED

NAME OF DOCTOR

NAME OF HOSPITAL

REGISTRY
BUREAU
HEALTHY COUNTRY
DEPARTMENT
MANITOBA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08540

08536

CERTIFICATE OF DEATH

Reg. Dist. No.

166

1. PLACE OF DEATH o. COUNTY Garrett			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,		c. LENGTH OF STAY IN 1b 2 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Friendsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kiser Nursing Home			d. STREET ADDRESS 15 Mi. So. Friendsville, Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Ada	Middle Vernon	Last Leighton	4. DATE OF DEATH August 20, 1957	Month Day Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1874	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY for others		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Isaac Leighton			14. MOTHER'S MAIDEN NAME Elizabeth Vernon		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Grace Falkenstein Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X <i>Acute Myocardial Failure</i>					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension Arteriosclerosis CVD w/o 8 years</i>					
DUE TO (c) <i>Hypertrophy</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 101 Third St.	20f. (City or town) (County) (State) Oakland, Md.
21. I certify that I attended the deceased from 15 May, 1957 to 20 Aug., 1957 that I last saw the deceased alive on 16 Aug., 1957 , and that death occurred at 8:15 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE A. E. Mance ADDRESS (Street, city or town, state) 101 Third St., Oakland, Md. DATE SIGNED 22 Aug. 1957					
PHYSICIAN'S NAME (Type) A. E. Mance, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/22/1957		22c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery	
22d. LOCATION (City, town, or county) Oakland, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton		ADDRESS Oakland, Md.		24a. RECD BY REGISTRAR J. J. Kavanagh	
VS A15 (4) 1SM 9/55		24b. REGISTRAR'S SIGNATURE J. J. Kavanagh			

AUG 27 1957

REGELVÉ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08537

CERTIFICATE OF DEATH

08541
166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 11	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GRACE		First I	Middle LEWIS.
4. DATE OF DEATH AUG - 1957		Last L	Month 8
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Nov. 20-1892		9. AGE (In years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) SWALLOW FALLS MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAREL SPIKER		14. MOTHER'S MAIDEN NAME JENNY SINES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT RICHARD A. LEWIS R-1 OAKLAND MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		Address INTERVAL BETWEEN ONSET AND DEATH 2 hours	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerotic Cardiovascular disease			
(b) DUE TO Arteriosclerotic Cardiovascular disease			
(c) Arteriosclerotic Cardiovascular disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 Nov., 1948, to 6 Aug., 1957 , that I last saw the deceased alive on 2 August, 1957 , and that death occurred at 5130 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Oakland Md 8 Aug '57			
ACTUAL SIGNATURE R. E. Simes M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG-9-1957	
22c. NAME OF CEMETERY OR CREMATORIAL SIMES CEMETERY		22d. LOCATION (City, town, or county) NEAR OAKLAND MD	
23. FUNERAL DIRECTOR'S SIGNATURE Emroy Golden		ADDRESS OAKLAND MD	
24a. REC'D BY REGISTRAR 1957		24b. REGISTRAR'S SIGNATURE Julie M. Howson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED - DEPARTMENT OF DEFENSE
U.S. GOVERNMENT PRINTING OFFICE 1957 5-300

CERTIFICATE OF DEATH

BUREAU V. A.

AUG 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08538

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08542
066

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY GARRETT				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XI RURAL FRIENDSVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS ROUTE #1			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First RANDALL	Middle EUGENE	Last LOWDERMILK	4. DATE OF DEATH	Month AUGUST	Day 14	Year 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	b. DATE OF BIRTH 10/8/39	9. AGE (In years less birthday) 17 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER			10b. KIND OF BUSINESS OR INDUSTRY Fathers Farm	11. BIRTHPLACE (State or foreign country) FRIENDSVILLE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT E. LOWDERMILK				14. MOTHER'S MAIDEN NAME AMANDA VAN SICKLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT R. E. Lowdermilk		Address R. D. Friendsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub dural Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 822X (b) Cerep - Commissural fusi. left par DUE TO (c) Centrally, lungs Green seedling							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Automobile turned over			
20c. TIME OF INJURY Hour 3:15 o. m. 8/11 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State road near Friendsville, Garrett Co.		20f. (City or town) (County) (State) FRIENDSVILLE, MARYLAND	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> S. J. Baumgartner							
ACTUAL SIGNATURE S. J. Baumgartner				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E. I. BAUMGARTNER, M. D.				DATE SIGNED 8/15/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/17/1957		22c. NAME OF CEMETERY OR CREMATORIUM Blooming Rose Cemetery		22d. LOCATION (City, town, or county) (State) Near Friendsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton				ADDRESS Oakland, Md.			
24a. REC'D BY REGISTRAR 8/15/57				24b. REGISTRAR'S SIGNATURE J. W. Johnson			

AT 2000 HRS ON 10 JUN 90 THE MIA'S WIFE ARRIVED AT THE AIRPORT
HEADING FOR CANTON, CHINA TO MAKE A PERSONAL VISIT.

BUREAU V. 5

AUG 27 1957

REGGIE EDE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08539

CERTIFICATE OF DEATH

085436

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		d. STREET ADDRESS 1		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Anna	Middle Ples	Last Mance	4. DATE OF DEATH	Month Aug.	Day 5	Year 1957
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1882	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Croatia, Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Mija Ples		14. MOTHER'S MAIDEN NAME Barbara Yakin						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Dr. A. E. Mance, Oakland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 290.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		<i>Hypostatic pneumonia</i>				INTERVAL BETWEEN ONSET AND DEATH 4 days		
DUE TO (b) DUE TO (c)		<i>arteriosclerotic Embolus Vascular disease 2 1/2 yrs</i>		<i>Pneumonia</i>		10 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Oakland, Md.		
ACTUAL SIGNATURE A. E. Mance						DATE SIGNED 8 Aug '57		
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/7/57		22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Emrys Bolden		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE 8/7/57		24b. REGISTRAR'S SIGNATURE Julia Brown ER		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 380007248-167488 90 19880764901 20A78 04017844

BUREAU V. S.

AUG 14 1957

REGELIV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 shall be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG219 9-3-57 et

08540

CERTIFICATE OF DEATH

08544

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND	c. LENGTH OF STAY IN 1b 2 MONTHS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND/Balto. MD	d. STREET ADDRESS 1302 Roland Avenue
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WEEKS NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) TACY	First	Middle	4. DATE OF DEATH Acc. 10 1957
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY-5-1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) WILMINGTON OHIO	
12. CITIZEN OF WHAT COUNTRY? U.S.		9. AGE (In years lost birthday) 85 yrs.	
13. FATHER'S NAME ABE. WALKER.		14. MOTHER'S MAIDEN NAME MARY JANE PATTERSON.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 33IX		16. SOCIAL SECURITY NO. 17. INFORMANT MRS. WILSON K. LEUERING JR. BALTO. MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) ARTERIO SCLEROSIS (c)		Address 4302 ROLAND AV. INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of Rt. Femur - 1956		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 5, 1957 , to August 10, 1957 , that I last saw the deceased alive on July 10, 1957 , and that death occurred at 10:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E.L. Baumgartner		ADDRESS (Street, city or town, state) 25 Alder St Oakland Md	
PHYSICIAN'S NAME (Type) E.L. BAUMGARTNER		DATE SIGNED 8/10/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG-12-1957	
22c. NAME OF CEMETERY OR CREMATORIUM SUGAR GROVE CEMETERY		22d. LOCATION (City, town, or county) WILMINGTON OHIO.	
23. FUNERAL DIRECTOR'S SIGNATURE Emroy Bolden		ADDRESS OAKLAND MD	
24a. RECEIVED BY REGISTRAR 8/10/57		24b. REGISTRAR'S SIGNATURE Jillie O'Rowan	

CERTIFICATE OF DEATH

NAME

HANSON

NAME

JETTA

CITY-HANSON

CITY-JETTA

CITY-JETTA

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RECEIVED
AUG 14 1957

BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08541 CERTIFICATE OF DEATH

085456

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 5 HRS. 15 MIN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First FANNIE	Middle Elliott	Last SMOUSE
4. DATE OF DEATH	Month AUGUST	Day 12	Year 1957
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 20, 1888
9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ADAM ELLIOTT	14. MOTHER'S MAIDEN NAME MARTHA PAUGH		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. -----	17. INFORMANT DANIEL SMOUSE	Address ROUTE 2, OAKLAND, MARYLAND
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Myocardial Infarction, Acute 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause lost. (b) Arteriosclerotic heart disease Years (c)			
INTERVAL BETWEEN ONSET AND DEATH Minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 58 2nd St. Oakland, Md.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 20, 1949 , to Aug. 14, 1957 , that I last saw the deceased alive on Aug. 12, 1957 , and that death occurred at 7:50 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE JAMES H. FEASTER, JR. M.D. ADDRESS (Street, city or town, state) 58 2nd St. Oakland, Md. DATE SIGNED Aug. 13, 1957			
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR. M. D.	OAKLAND, MARYLAND		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/15/1957	22c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery	22d. LOCATION (City, town, or county) (State) Oakland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton	ADDRESS Oakland, Md.	24a. REC'D. BY REGISTRAR DATE 9/13/57	24b. REGISTRAR'S SIGNATURE Pawley

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

RECEIVED	SEARCHED	INDEXED	SERIALIZED	FILED
BUREAU V. S.				
AUG 27 1957				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08542 CERTIFICATE OF DEATH

08546

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEER PARK	c. LENGTH OF STAY IN 1b RURAL and give nearest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 DEER PARK.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BOWSER NURSING HOME		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOSEPH	First SILAS	Middle TEETS	4. DATE OF DEATH AUG 25 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE-13-1881
9. AGE (In years lost birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Month Aug
13. FATHER'S NAME SILAS TEETS.	14. MOTHER'S MAIDEN NAME HANNAH SHOYER.		15. CITIZEN OF WHAT COUNTRY? U.S.
16. SOCIAL SECURITY NO. 230-03-7288	17. INFORMANT SOSIE TEETS	Address BLOOMINGTON MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Acute Myocardial suffusion 3 days			
(b) Cerebral Hemorrhage with its fatal paroxysm 5 days			
(c) Chronic Cardiac Failure and Deam 3 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from Aug 25 , 1957, to Aug 25 , 1957, that I last saw the deceased alive on Aug 24 , 1957, and that death occurred at 3:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph Calandrella	PHYSICIAN'S NAME (Type) Ralph Calandrella	ADDRESS (Street, city or town, state) Kittansville, Md	DATE SIGNED Aug 27-57
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF AUG-28-1957	22c. NAME OF CEMETERY OR CREMATORIUM GEORGE CEMETERY	22d. LOCATION (City, town, or county) (State) NEAR SWANTON MD.
23. FUNERAL DIRECTOR'S SIGNATURE Emroy Bolden	ADDRESS OAKLAND MD	24a. REC'D BY REGISTRAR 8/28/57	24b. REGISTRAR'S SIGNATURE Emroy Bolden

CERTIFICATE OF DEATH

BUREAU V. 1
RECEIVED
SEP 5 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08547
166

08543

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 which should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <i>Garrett Co.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oakland</i>	c. LENGTH OF STAY IN 1b <i>18 mo.</i>	b. COUNTY <i>Maryland</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>WEEK's Nursing Home</i>		d. STREET ADDRESS <i>814 Camden Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>ALVINA</i>	First <i></i>	Middle <i></i>	Lost 4. DATE OF DEATH <i>TEUFEL</i> Month 8 Day 13 Year 1957
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 5, 1869</i>
9. AGE (In years last birthday) <i>87 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Brandt</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Mrs. Harry D. Schmidt</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i></i>	
		(b) DUE TO <i>Degenerative Cardiovascular Disease</i> 10 years	
		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized bodily debility</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 12, 1957</i> to <i>Aug 13, 1957</i> that I last saw the deceased alive on <i>Aug 12, 1957</i> , and that death occurred at <i>6:40 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Albert H. Lighton</i> M.D. ADDRESS (Street, city or town, state) <i>77 Oak Street</i> DATE SIGNED <i>13 Aug 1957</i> PHYSICIAN'S NAME (Type) <i></i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug. 15, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Western Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein, Inc. Cumberland, Md.</i>		ADDRESS <i></i>	
		24a. REC'D BY REGISTRAR <i>8/14/57</i>	
		24b. REGISTRAR'S SIGNATURE <i>Julie A. Rowan</i>	

BUREAU V. S.

AUG 57 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08544 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	0854866				
										Reg. Dist. No.					
1. PLACE OF DEATH a. COUNTY GARRETT					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND					c. LENGTH OF STAY IN 1b 3 weeks					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DISTRICT OF COLUMBIA					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL					d. STREET ADDRESS 1217 13th STREET N.W.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JESSIE CONNEWAY		First	Middle	Lost	4. DATE OF DEATH AUGUST 7 1957		Month	Day	Year						
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 18. 1884		9. AGE (in years last birthday) 72 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Int. Rev. Serv			10b. KIND OF BUSINESS OR INDUSTRY U.S. Government			11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? UNITED STATES						
13. FATHER'S NAME CONNEWAY, DAVID L.					14. MOTHER'S MAIDEN NAME ASHBY, ELIZA JANE					Address Oakland, Md.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. J. A. Duffy			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 823X Automobile Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture left tibia - Laceration leg. DUE TO (c) Fracture mandible - Fracture b, 7, 8, 9 ribs DUE TO Fracture mandible - Fracture b, 7, 8, 9 ribs INTERVAL BETWEEN ONSET AND DEATH 18 m						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture mandible - Fracture b, 7, 8, 9 ribs										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile accident - Ran over unknown												
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> p.m. July 16 1957			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State Road near Kitzmiller Garrett Md.			20f. (City or town) Oakland		(County) Kitzmiller Garrett		(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE J. D. Baumgartner										M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 8/18/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 8/11/1957			22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery			22d. LOCATION (City, town, or county) Oakland, Md.						
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton										ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR 8/10/57		24b. REGISTRAR'S SIGNATURE Jessie Conneway	

REGISTRATION AND EXAMINATION CERTIFICATE OF DEATH

BUREAU V. S.

AUG 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C8545 CERTIFICATE OF DEATH

08549
766

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 1 Day		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport 0143.2		
3. NAME OF DECEASED (Type or print)	First Marie	Middle Bridgett	Last Williams	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH Oct. 3, 1881	4. DATE OF DEATH Aug	
	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) yrs. 75	Month Day Year 30 1957	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luke Kearney	14. MOTHER'S MAIDEN NAME not known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Joseph Taylor-Westernport, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Chronic Myocarditis and Myocardiol Degeneration not specified as Rheumatic			INTERVAL BETWEEN ONSET AND DEATH 5 Years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 27, 1957, to Aug. 30, 1957, that I last saw the deceased alive on Aug. 29, 1957, and that death occurred at 410 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Paul G. Nelson M.D. ADDRESS (Street, city or town, state) Piedmont, W. Va. DATE SIGNED 8-31-57				
PHYSICIAN'S NAME (Type)				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/3/57	22c. NAME OF CEMETERY OR CREMATOR Y St. Peters Cem	22d. LOCATION (City, town, or county) Westernport	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE El Boral		ADDRESS Westernport, Md.	24a. REC'D BY REGISTRAR 9/3/57	24b. REGISTRAR'S SIGNATURE J. J. B. B. away

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 5 1957

REGELIVED